PATIENT INFORMATION

Name_____ Birthdate_____
Last First Middle mth/day/year

Home Address_____
Number Street City Postal Code

Telephone (home)_____ Cell #_____

E-mail address:_____

Employer_____ Occupation_____

Business Address_____
Number Street City Postal Code

Business Telephone_____

Whom may we thank for recommending us?_____

Parent or Spouse's Name _____ Birthdate _____

Children's Name (s) _____ Birthdate _____
_____ Birthdate_____
_____ Birthdate _____

INSURANCE INFORMATION

Policy holder's Name_____ & Birthdate _____
month/day/year

Insurance Company's Name_____ Group No. _____

SIN No. _____ Certificate No. _____ dep.no._____

Div./Act. No. _____ Coverage A_____% B_____% C_____%

Annual Limit: _____ Employer_____

Do you have a second dental plan?_____

FINANCIAL ARRANGEMENTS AVAILABLE IN OUR OFFICE

We will accept payment from your dental insurance company for the services covered on your plan. For the services not covered or only partly covered, you can pay in any of the following ways:

1. Cash
2. Visa
3. Master Card
4. Debit
5. American Express

We require payment in full at time of service.

MEDICAL HISTORY

Family Physician_____Telephone_____
Address_____

PLEASE CHECK YES OR NO

YES NO

☐ ☐ Do you have any current medical problems? What? _____
☐ ☐ Have you seen your physician within the last year? For what? _____
☐ ☐ Is there anything abnormal with your heart? What? _____
☐ ☐ Are you taking any pills, drugs or medicines? What? _____
☐ ☐ Are you pregnant?
☐ ☐ Have you noticed any unusual lumps or swellings on your head or in your neck? Where?____
_____
☐ ☐ Do you have any growths or swellings or sores in your mouth? _____
☐ ☐ Are you allergic to anything? What? _____

Please describe type of reaction: _____
_____
_____

Are you allergic to any of the following medications? **Circle if yes**

Dental anaesthisia (freezing)	Codeine
A.S.A. (aspirin)	Other _____
Penicillin	

Do you have or have you had any of the following conditions; **Circle if yes**

Rheumatic Fever	Diabetes	Epilepsy
Heart Murmur	Hepatitis	Tuberculosis
High Blood Pressure	Kidney Condition	Venereal Disease
Cancer	Liver Damage	AIDS

Please note: This office makes use of CDAnet whenever possible to submit insurance claims.

I authorize release, to my insuring company plan administrator, the information contained in claims submitted electronically. I hereby assign my benefits payable from claims submitted electronically to Dr. Gloria Yan and/or her associates, and authorize payments directly to her/him.

Date:_____Signature:_____
NOTES:_____
_____
_____
_____
_____
_____